U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 08 March 2007

In the Matter of:

J.L., Case No.: 2006-BLA-05007
Claimant

v.

FRIENDSHIP ENERGY, INC.,
Employer

NATIONAL UNION FIRE INSURANCE CO.,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Bruce Yonts, Esq.
Greenville, Kentucky
For the Claimant

Brett Stonecipher, Esq.
Ferreri & Fogle
Lexington, Kentucky
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq.* The Act and implementing regulations, 20 CFR Parts 410, 718, 725, and 727, provide compensation and other benefits to living coal miners, who are totally disabled due to pneumoconiosis, and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C.

§ 902(b); 20 CFR § 718.201 (2006). In this case, the Claimant alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on August 15, 2006, in Bowling Green, Kentucky. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2006). The Director, OWCP, was not represented at the hearing. The Claimant and his wife testified. Transcript ("Tr.") at 14, 39. Director's Exhibits ("DX") 1-32, Claimant's Exhibits ("CX") 1-4, and Employer's Exhibits ("EX") 1-3 and 6 were admitted into evidence without objection (Tr. 7-13). CX 5, a list of the Claimant's medications prepared by his wife, was admitted over the Employer's objection (Tr. 43). The record was held open for the Employer to submit EX 4 and 5, re-readings of x-rays relied upon by the Claimant (Tr. 8-10). EX 4 and 5 are hereby admitted into evidence. The Claimant and the Employer submitted closing arguments, and the record is closed.

In reaching my decision, I have reviewed and considered the entire record, including all exhibits, the testimony at the hearing, and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim on October 20, 1999 (DX 1). It was administratively denied by the District Director of the Office of Workers' Compensation Programs ("OWCP") on April 18, 2000, on the grounds that the Claimant failed to respond to the Director's February 2, 2000, letter, and the Director deemed the claim to be abandoned. The Claimant did not appeal that determination.

The Claimant filed his second claim on September 23, 2004 (DX 3). The Claimant was awarded benefits by the Director, OWCP, on July 12, 2005 (DX 24). The Employer appealed (DX 26), and the claim was forwarded to the Office of Administrative Law Judges for hearing on September 27, 2005 (DX 30).

APPLICABLE STANDARDS

This claim relates to a "subsequent" claim filed on September 23, 2004. Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2006). Pursuant to 20 CFR § 725.309(d) (2006), in order to establish that he is entitled to benefits, the Claimant must demonstrate that "one of the applicable conditions of entitlement … has changed since the date upon which the order denying the prior claim became final" such that he now meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203, and 718.204 (2006). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Labelle Processing Company v. Swarrow*, 72 F.3d 308 (3rd Cir. 1996); *Lisa Lee Mines v.*

Director, OWCP, 86 F.3d 1358 (4th Cir. 1996); *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994).

ISSUES

The issues contested by the Employer are:

1. Whether the Claimant suffers from pneumoconiosis.

2. Whether the Claimant's pneumoconiosis arose out of coal mine employment.

3. Whether his disability is due to pneumoconiosis.

4. Whether the evidence establishes that one of the applicable conditions of entitlement has changed pursuant to 20 CFR § 725.309 (2006).

DX 30; Tr. 6. The Employer withdrew the issues of the timeliness of the claim, whether the Claimant was a miner, and whether it is the responsible operator (Tr. 6). The Employer conceded 25 years of coal mine employment (Tr. 6). The Employer also reserved its right to challenge the statute and regulations (Tr. 6). Although the Employer initially contested whether the Claimant is totally disabled (Tr. 6), it conceded that he is disabled in its closing brief. *See* Brief on Behalf of Friendship Energy, Inc., and American International South, filed December 4, 2006, at 13.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant was born in 1938 (DX 3; Tr. 14). He completed the 12th grade (Tr. 14). The Claimant has one dependent for purposes of augmentation of benefits, his wife (DX 3; DX 9; Tr. 39).

The Claimant's Employment History form lists coal mine employment from 1969 to 1997 (DX 4). The Claimant's FICA earnings worksheet lists coal mine employment from 1969 to 1997 (DX 6). Based on Social Security earnings, I find that the Claimant has established 28 years of coal mine employment. On his Employment History, the Claimant stated that over the relevant period he was a heavy equipment operator at a strip mine (DX 5; Tr. 15).

The Claimant testified that he regularly coughs and spits up sputum (Tr. 24). Sometimes he can walk a city block, and at other times, he is unable to walk that far due to shortness of breath (Tr. 26). He has been taking several breathing medications for seven or eight years (Tr. 29; *see* CX 5 for a list of his current medications). He has been prescribed oxygen for use both at night and any time he lies down (Tr. 36). The Claimant testified to a smoking history of up to 50 years at a rate of about one pack of cigarettes per day, stopping two years before the hearing (Tr. 37).

The Claimant's last coal mine employment was in the Commonwealth of Kentucky (DX 3). Therefore, this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*).

Material Change in Conditions

In a subsequent claim, the threshold issue is whether one of the applicable conditions of entitlement has changed since the previous claim was denied. The Claimant's previous claim was denied by the District Director on April 18, 2000, by reason of abandonment. Thus, the Claimant failed to establish any element of entitlement in the prior claim. 20 CFR § 725.409(c). The Employer conceded in its closing brief that the Claimant is totally disabled by a pulmonary or respiratory impairment. This constitutes a change in one of the applicable conditions of entitlement.[1] Because the new evidence establishes that a change in conditions has occurred, I must consider all of the evidence in the record in reaching my decision whether he is now entitled to benefits. Evidence admitted in the prior claim may be considered notwithstanding the limitations on the introduction of evidence contained in 20 CFR § 725.414 (2006). 20 CFR § 725.309(d)(1) (2006). Moreover, no findings in the prior claim are binding, unless a party fails to contest an issue, or made a stipulation in a prior claim. 20 CFR § 725.309(d)(4) (2006).

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case. X-ray interpretations submitted by the parties in connection with the current claim in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print. Treatment records and records from the prior claim are not subject to the limitations.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may be classified as round (p, q, r), or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater

[1] In *Grundy Mining Co. v. Director, OWCP [Flynn]*, 353 F.3d 467 (6th Cir. 2003), a multiple claim arising under the pre-amendment regulations at 20 C.F.R. § 725.309 (2000), the Court reiterated that its previous decision in *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994) requires that the ALJ resolve two specific issues prior to finding a "material change" in a miner's condition: (1) whether the miner has presented evidence generated since the prior denial establishing an element of entitlement previously adjudicated against him; and, (2) whether the newly submitted evidence differs "qualitatively" from evidence previously submitted. Specifically, the *Flynn* Court held that "miners whose claims are governed by this Circuit's precedents must do more than satisfy the strict terms of the one-element test, but must also demonstrate that this change rests upon a qualitatively different evidentiary record." *See also, Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602, 608-610 (6th Cir. 2001). Once a "material change" is found, then the ALJ must review the entire record *de novo* to determine ultimate entitlement to benefits. It is not clear how *Grundy* should be applied when the prior claim was denied by reason of abandonment. In any event, the record in the current claim is qualitatively different from the prior claim on the issue of total disability, because recent pulmonary function tests meet the standard for disability, while the tests in the prior claim did not.

than 1 cm) may be classified as A, B, or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, and 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2006). Any such readings are, therefore, included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications of physicians who read x-rays for pneumoconiosis have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH), and/or the registry of physicians' specialties maintained by the American Board of Medical Specialties.[2] If no qualifications are noted for any of the following physicians, it means that either they have no special qualifications for reading x-rays, or I have been unable to ascertain their qualifications from the record, the NIOSH lists, or the Board of Medical Specialties. Qualifications of physicians are abbreviated as follows: A=NIOSH certified A reader; B=NIOSH certified B reader; BCR=Board-certified in Radiology. Readers who are Board-certified Radiologists and/or B readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be Radiologists.

Date of X-ray	**Read as Positive for Pneumoconiosis**	**Read as Negative for Pneumoconiosis**	**Silent as to the Presence of Pneumoconiosis**
11/30/99		DX 1 Traughber A DX 1 Sargent BCR/B	
01/21/00		DX 1 Powell B DX 1 Scott BCR/B DX 1 Wheeler BCR/B	
05/10/04			EX 6 Bickett (No acute cardiopulmonary disease)
10/11/04		DX 11 Westerfield B	DX 12 Barrett, B/BCR Quality only: Fair

[2] NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, Comprehensive List of NIOSH Approved A and B Readers, February 2, 2007, found at http://www.oalj.dol.gov/PUBLIC/BLACK LUNG/REFERENCES/REFERENCE_WORKS/BREAD3_02_07.HTM . Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the website of the American Board of Medical Specialties, found at http://www.abms.org.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
12/08/04			EX 6 Bea (No acute or active disease)
02/10/05			EX 6 Myers (Essentially normal)
06/23/05		EX 1 Selby B EX 3 Dahhan B	
02/06/06	CX 1 Baker B 1/0	EX 4 Spitz B/BCR	
07/24/06	CX 4 Baker B 1/0	Spitz B/BCR	CX 2 Verhulst (Chronic changes in the lung bases likely related to COPD.)

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-33 to 1-34 (1991).

A CT scan of the Claimant's chest was taken on July 2, 2002, because of a lung mass (EX 6). The radiologist opinion stated that there were moderate to large bilateral basilar effusion and equivocal findings suggesting a mass and metastatic disease to the liver and adrenal glands.

A second CT scan was taken on June 23, 2005, in connection with an examination by Dr. Selby on behalf of the Employer, described below. Both Dr. Anthony Perkins, a Board-certified Radiologist (EX 1), and Dr. Dahhan, a B reader (EX 3), interpreted it to be negative for pneumoconiosis.

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. Tests most often relied upon to establish disability in black lung claims measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1), and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in this case. Pulmonary function studies submitted by the parties in connection with the current claim in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print. Treatment records and records from the prior claim are not subject to the limitations. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and

either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2006).

Ex. No. Date Physician	**Age Height**[3]	**FEV_1 Pre-/ Post**	**FVC Pre-/ Post**	**FEV_1/ FVC Pre-/ Post**	**MVV Pre-/ Post**	**Qualify?**	**Physician Impression**
DX 1 11/30/99 Traughber	60 68”	1.79	2.98		38.0	No	Moderate obstructive ventilatory deficit. Not acceptable per Dr. Burki (DX 1)
DX 1 01/20/00 Simpao	61 66”	2.16	3.42		92	No	Moderate obstructive disease.
DX 1 01/21/00 Powell	61 66.5”	1.92	2.85	67%		No	Mild obstructive defect.
CX 3 04/11/02 Chavda	63 68”	1.25 1.15	2.24 1.96	56%/ 59%	--- 20	Yes Yes	Obstructive, restrictive airway disease without any bronchodilator response.
EX 6 05/20/03 Majmudar	64 68”	1.67 1.79	2.48 2.81	67% 69%		No No	Moderate obstruction. Mild restriction.
EX 6 06/28/04 Majmudar	65 68”	1.40 1.49	2.16 2.11	65% 71%		Yes Yes	Moderate obstruction.
DX 11 10/08/04 Simpao	65[4] 66”	1.30	1.91	68%	50	Yes	Severe Restrictive and Obstructive disease. Technically acceptable per Dr. Mettu, DX 11. Invalid per Dr. Selby, EX 2.

[3] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the Miner from 65” to 68”, I have taken the mid-point (66.5”) in determining whether the studies qualify to show disability under the regulations.

[4] Due to an error in the date of birth recorded for the Miner, the test report listed the Claimant’s age as 64.

Ex. No. Date Physician	Age Height[3]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
EX 1 06/23/05 Selby	66 65"	1.09 0.98	1.75 1.56	62% 63%		Yes Yes	Moderate obstructive defect without improvement after broncho-dilator. Spirom-etry inconsistent due to question-able effort. Dr. Selby said they were valid. EX 2 at 10.
CX 1 02/06/06 Baker	67 66"	1.23	1.90	65%	N/A	Yes	Possible moder-ate obstructive defect. Tracings nonreproducible.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (pO_2) and the percentage of carbon dioxide (pCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli, which may leave the miner disabled.

The following chart summarizes the newly submitted arterial blood gas studies available in this case. Arterial blood gas studies submitted by the parties in connection with the current claim in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print. Treatment records and records from the prior claim are not subject to the limitations. A "qualifying" arterial blood gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contra-indicated. 20 CFR § 718.105(b) (2006).

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify?	Physician Impression
DX 1	11/30/99	Traughber	41	77	No	Normal
DX 1	01/21/00	Powell	33.1	160.6	--	pO_2 is fallacious.
DX 11	10/08/04	Simpao	41.5	85.1	No	Normal
EX 1	06/24/05	Selby	47.0	56.0	Yes	

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify?	Physician Impression
CX 1	02/16/06	Baker	40.0	71.0	No	Resting hypoxemia

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2006). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2006). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be, nevertheless, found if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, *i.e.*, performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2006). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2006). The record contains the following medical opinions.

Treatment Records

The Claimant was hospitalized for pneumonia in March 2002 (CX 3). While in the hospital, he was seen in consultation by Dr. Sanjay Chavda. According to the website of the American Board of Medical Specialties, Dr. Chavda is Board-certified in Internal Medicine and Pulmonary Disease. Dr. Chavda noted the Claimant's history of 50+ years of smoking, and his work in strip mines. Dr. Chavda's diagnoses were pneumonia, chronic obstructive pulmonary disease exacerbation, bronchitis, and diabetes. Dr. Chavda saw the Claimant in follow-up on April 11, 2002 (CX 3). He performed a pulmonary function test which showed obstructive and restrictive disease without any bronchodilator response. The results of the test are reported on the table above. Dr. Chavda's impressions were severe COPD, chronic bronchitis, swelling in the legs, and uncontrolled diabetes.

The Claimant was seen periodically thereafter by another Pulmonologist practicing with Dr. Chavda, Dr. Manoj Majmudar (EX 6). Dr. Majmudar saw the Claimant about every three months, assessing severe chronic obstructive disease, chronic bronchitis and coronary artery disease. On July 2, 2002, the Claimant presented with pleural effusion. Dr. Majmudar reported the results of the June 2002 CT scan and advised the Claimant to undergo thoracentesis, which did not reveal any malignancy. On July 17, 2002, Dr. Majmudar referred the Claimant for a

cardiology work-up. Later added diagnoses included asthma, diabetes and congestive heart failure. The Claimant was reported as "doing fairly well" at most visits, including his last reported visit on December 13, 2004.

The record contains additional treatment notes for the Claimant dated 2002 through 2005 (EX 6). Treatment was generally for heart-related ailments, with occasional diagnoses of asthma, COPD, congestive heart failure, diabetes, renal failure, emphysema, and chronic bronchitis. The Claimant was prescribed 16 medications at one point of treatment. The Claimant was diagnosed with ischemic cardiomyopathy, and underwent cardiac catheterization in August 2002 and February 2003, bypass surgery in April 2003, and hospitalization for congestive heart failure in May 2004.

Medical Opinions Given in Connection with the Black Lung Claims

Dr. Sam Traughber examined the Claimant on behalf of the Department of Labor on November 30, 1999, in connection with the Claimant's first claim (DX 1). Dr. Traughber is Board-certified in Internal Medicine, and was an A reader at the time of the examination. He took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, EKG, blood gas studies, and pulmonary function testing. He reported that the Claimant worked in the mines for 22 years. He reported a smoking history of one pack per day for 20 years. The chest examination was normal. Dr. Traughber read the x-ray as showing no pneumoconiosis. The pulmonary function test showed moderate obstructive ventilatory deficit . The arterial blood gas study was normal at rest. The EKG was abnormal, suggestive of right ventricular enlargement with chronic lung disease. Dr. Traughber diagnosed obstructive ventilatory deficit and a past history of nicotine addition due to cigarette smoking, and chronic bronchitis due to a history of sputum production daily. Dr. Traughber said he thought the Claimant had a moderately severe impairment judged from his pulmonary function test, which he said appeared to be due to cigarette smoking. He said the Claimant did not have an occupational lung disease caused by coal mine employment. He said that the Claimant did not have the respiratory capacity to perform the work of a miner or comparable work in a dust-free environment.

Dr. Robert Powell examined the Claimant on behalf of the Employer on January 21, 2000, in connection with the prior claim (DX 1). Dr. Powell is board-certified in Internal Medicine and Pulmonary Disease, and a B reader. He took occupational, social, family, and medical histories, and conducted a physical examination, EKG, chest x-ray, blood gas studies, and pulmonary function testing. He reported that the Claimant worked in the mines for 26 years. He reported a smoking history from age 15 at one pack per day, decreasing to one-half pack per day several years before the examination. The chest examination was normal. Dr. Powell read the x-ray as negative for pneumoconiosis, 0/0. The pulmonary function test showed mild obstructive defect. The arterial blood gas study was fallacious, but oxygen saturation was 100%. Dr. Powell diagnosed no coal workers' pneumoconiosis, a pulmonary emphysema with mild obstructive ventilatory defect, and status post recent left carotid endarterectomy. Dr. Powell did not make any statement about disability.

Dr. Valentino Simpao, who lists no medical specialty credentials, examined the Claimant on behalf of the Department of Labor on October 8, 2004 (DX 11). He noted 26 years of coal mine employment, past history of asthma, heart disease, diabetes, and high blood pressure,

symptoms of sputum, wheezing, dyspnea, cough, orthopnea, ankle edema, and PND. He noted a 50+ year smoking history with current smoking of five to six cigarettes per day. On examination, lungs had increased resonance, crepitations, and wheezing. X-ray was negative for pneumoconiosis. Pulmonary function testing showed severe restrictive and obstructive airway disease. Arterial blood gases were normal, and EKG showed complete right bundle branch block. Dr. Simpao diagnosed coal workers' pneumoconiosis based on pulmonary function testing, physical examination, and symptoms. He opined that the Miner was totally disabled from his prior coal mine employment. In discussing etiology of disability, he opined that the "primary cause would be his multiple years of coal dust exposure. However, he does have a 52 pack year history of smoking, therefore the degree these factors influenced his pulmonary impairment is unable to be determined."

Dr. Simpao submitted a November 15, 2004, letter stating that the Miner suffers from coal workers' pneumoconiosis based on his "long standing history of coal dust exposure." He opined that the Miner is totally disabled, based on symptoms, physical examination, pulmonary function test, and EKG. He noted significant coal dust exposure, smoking history, coronary artery disease and asthma. "The degree these factors influenced his pulmonary impairment is unable to be determined."

Dr. Jeff Selby, a Board-certified Internist, Pulmonologist, and B reader, examined the Claimant on behalf of the Employer on June 23, 2005 (EX 1). He noted the Miner's employment history, complaints of trouble breathing, past history of asthma, kidney stones, and heart disease, and smoking history of approximately 50 pack years. Physical examination showed much decreased breath sounds with wheezes and prolonged expiratory phase. The Claimant was obese and had an insulin pump inserted in left lower quadrant. EKG showed right bundle branch block. X-ray and CT scan were negative for pneumoconiosis. Pulmonary function study showed moderate obstructive defect with no improvement after bronchodilator, normal lung volumes and normal diffusion capacity. Dr. Selby diagnosed no pneumoconiosis, moderate obstructive pulmonary defect due to 50+ years of cigarette smoking, inadequately treated bronchial asthma, severe cardiac disease and emphysema due to cigarette smoking, uncontrolled diabetes, and a possibly malignant right adrenal mass. He opined that the pulmonary and cardiac problems were brought on and exacerbated by smoking and that asthma would have occurred whether or not the Miner had smoked or had been exposed to coal dust. He opined that none of the ailments described were caused by or contributed to by coal dust exposure or pneumoconiosis.

Dr. Selby was deposed by the Employer on May 2, 2006, where he repeated the findings in his earlier written report (EX 2). He noted that the Miner's last coal mine employment was welding and running a bull dozer. He opined that the interstitial markings on the Claimant's x-ray were in a localized area and not the right type of distribution pattern to indicate pneumoconiosis. He opined that the emphysema seen was bullous emphysema unrelated to the type of emphysema that can occur around coal macules. He reiterated that the Miner does not suffer from clinical pneumoconiosis based on negative x-ray, CT scan, physical examination, and testing, including pulmonary function tests. He said if the Claimant had clinically significant pneumoconiosis, there would be a reduction in the diffusion capacity and a restrictive pattern most likely seen on the lung volumes. He opined that the Miner does not suffer from legal pneumoconiosis because family history, asthma, and smoking history, and results from physical examination and pulmonary function testing, fit the classic pattern of cigarette smoking ailments.

In his opinion, the objective testing "all fits into a much better package [for a cigarette and asthma etiology] than if you try to bend that thinking and incorporate coal mine dust as a causative factor." He reviewed Dr. Simpao's pulmonary function test and opined that it was invalid due to greater than 5% variation between FEV_1 readings. Dr. Selby said that based on his own studies, the Claimant was totally disabled from a pulmonary standpoint from performing the work of a miner or similarly arduous work in a dust-free environment.

Dr. Baker, who is Board-certified in Internal Medicine and Pulmonary Disease and a B reader, examined the Claimant at the request of his counsel on February 6, 2006 (CX 6). Dr. Baker noted 29 years of coal mine employment, 50 years of smoking one pack per day, and past history significant for pneumonia, asthma, bronchitis, heart disease, cancer, high blood pressure, and symptoms of sputum, wheezing, dyspnea, cough, chest pain, and ankle edema. On examination, lungs showed bilateral wheezing. The x-ray was interpreted as 1/0. Pulmonary function study showed moderate obstructive defect, but Dr. Baker questioned the validity of the results due to nonreproducible tracings. He also noted, however, that the Claimant was short of breath at rest. Arterial blood gas showed mild resting hypoxemia. He did not conduct an exercise study because of the Claimant's heart disease. He diagnosed coal workers' pneumoconiosis, based on an abnormal x-ray and a history of coal dust exposure; COPD, based on pulmonary function testing; chronic bronchitis based on history; hypoxemia, based on the arterial blood gas studies; and heart disease status post coronary artery bypass, angioplasty and stent, based on past history. He opined that all ailments except the heart disease are due to a combination of cigarette smoking and coal dust exposure. He said that possible obstructive disease, chronic bronchitis, and resting arterial hypoxemia "may have been caused predominately by his cigarette smoking but his coal dust has been a significant contributing factor." He stated that it was unclear if the Claimant retained the respiratory capacity to perform the work of a coal miner based on the nonreproducible pulmonary function studies.

Dr. A. Dahhan, a Board-certified Internist, Pulmonologist, and B reader, reviewed the Claimant's medical records and prepared a report dated May 18, 2006, at the request of the Employer (EX 3). Dr. Dahhan diagnosed no clinical pneumoconiosis based on negative CT scan and x-ray. He opined that the Miner suffers from severe obstructive lung disease and severe loss of pulmonary function due to a heavy smoking history, congestive heart failure, and asthma. He opined that the ailments seen are fully explained by smoking and that a coal dust etiology does not fit with the evidence. EKG abnormalities were inconsistent with the variety of cor pulmonale secondary to coal dust exposure. Dr. Dahhan noted that negative CT scan and x-ray, a greatly reduced FEV_1 on pulmonary function test, and the administration and responsiveness to bronchodilators, all are inconsistent with the permanent ongoing damage caused by coal dust.

Total Pulmonary or Respiratory Disability

The Employer has conceded that the Claimant is totally disabled. A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2006), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2006). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and, (5) lay testimony. 20 CFR

§ 718.204(b) and (d) (2006). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2006); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that the Claimant suffers from complicated pneumoconiosis or cor pulmonale. The arterial blood gas studies are inconclusive, as only one test, not the most recent, resulted in a qualifying value. The pulmonary function tests, on the other hand, have all resulted in qualifying values since June 2004. Moreover, despite the questionable validity of some of the pulmonary function tests, every physician who has given an opinion on the issue, with the exception of Dr. Baker, who was uncertain due to his nonreproducible pulmonary function study, has said that the Claimant is disabled. I find that the preponderance of the evidence supports the conclusion that the Claimant is totally disabled by a pulmonary or respiratory impairment.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical,' pneumoconiosis and statutory, or 'legal,' pneumoconiosis.
>
> > (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
> >
> > (2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2006). In this case, the Claimant's medical records indicate that he has been diagnosed with pneumoconiosis as well as chronic obstructive pulmonary disease and emphysema, which can be encompassed within the definition of legal pneumoconiosis. *Ibid*.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal mine dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003).

Twenty CFR § 718.202(a) (2006) provides that a finding of the existence of pneumoconiosis may be based on: (1) chest x-ray; (2) biopsy or autopsy; (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982), or 718.306 (applicable only to deceased miners); or, (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that the Claimant has had a lung biopsy and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the Claimant filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at § 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148 to 1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Of the available x-rays in this case, two have been read by one reader as positive, but by another reader as negative, for pneumoconiosis. For cases with conflicting x-ray evidence, the regulations specifically provide,

> … where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2006); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-37 (1991). Readers who are Board-certified

Radiologists and/or B readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). A Judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

All readings of the two x-rays admitted in the prior claim were negative. Thus, I find that both, taken November 30, 1999, and January 21, 2000, were negative.

Readings of three x-rays taken during treatment introduced into evidence in the current claim, taken on May 10, 2004, December 8, 2004, and February 10, 2005, were not read for the purpose of the claim, and the Radiologists who interpreted them made no mention of pneumoconiosis. Whether an x-ray interpretation which is **silent** as to pneumoconiosis should be interpreted as **negative** for pneumoconiosis is an issue of fact for the ALJ to resolve. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co.*, 6 B.L.R. 1-930 (1984). The readers of all three x-rays found no disease, and I find them to be negative.

The October 11, 2004, x-ray film was interpreted as negative by Dr. Westerfield, a B reader. With no conflicting interpretations in the record, I find that the October 11, 2004, x-ray evidence is negative for pneumoconiosis.

The June 23, 2005, x-ray was interpreted as negative by Drs. Dahhan and Selby, both B readers. As the record contains no conflicting interpretations, I also find that the June 23, 2005, x-ray is negative for pneumoconiosis.

The February 6, 2006, x-ray film was interpreted as positive by Dr. Baker, a B reader, and as negative by Dr. Spitz, a dually certified physician. I give greater weight to the more qualified reading by Dr. Spitz and find that the February 6, 2006, x-ray evidence is negative for pneumoconiosis.

Finally, the July 24, 2006, x-ray was also interpreted as positive by Dr. Baker and as negative by Dr. Spitz. Again, I give greater weight to the interpretation by the dually certified physician, Dr. Spitz. Dr. Verhulst, who originally interpreted the x-ray for the Claimant's treating physician, found changes likely related to COPD, but did not mention pneumoconiosis. I find his reading to be neither positive nor negative for pneumoconiosis. Considering all the readings, I find that the July 24, 2006, x-ray is negative for pneumoconiosis.

As I have found all of the x-ray films to be negative for pneumoconiosis, I further find that pneumoconiosis is not established through x-ray evidence.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G*

Construction Co., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the Judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the Judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (*en banc*).

None of the Claimant's treating physicians diagnosed coal workers' pneumoconiosis. Although they did diagnose chronic obstructive pulmonary disease, they did not offer opinions as to the cause. Histories noted both the Claimant's smoking and his coal mine employment. I find that the treatment records do not support a finding of either clinical or legal pneumoconiosis, but they do not weigh against a finding of legal pneumoconiosis.

Of the physicians who examined the Claimant or reviewed his records in connection with his black lung claims, Drs. Traughber, Powell, Selby, and Dahhan said that the Claimant does not have pneumoconiosis, while Drs. Simpao and Baker said that he does. Dr. Simpao found the x-ray taken as part of his examination of the Claimant to be negative, but nonetheless diagnosed pneumoconiosis based on the pulmonary function testing, physical examination, and symptoms. I construe his opinion to be a diagnosis of legal pneumoconiosis. Dr. Baker read the x-ray taken as part of his examination to be positive. He also said that coal dust and cigarette smoking contributed to the Claimant's obstructive disease. I construe Dr. Baker's opinion to be a diagnosis of both clinical and legal pneumoconiosis. All of the physicians who provided medical opinions did so based on adequate underlying documentation. All provided at least some rationale in support of their conclusions. Thus, I consider all of these medical opinions to represent documented and reasoned medical opinions.

I find that the weight of the medical opinion evidence supports the conclusion that the Claimant does not have clinical pneumoconiosis. Dr. Baker's opinion that the Claimant has clinical pneumoconiosis is based upon x-rays which he found to be positive, but I have found to be negative. Similarly, the CT scans did not support a finding of clinical pneumoconiosis. As the medical opinions that the Claimant does not have clinical pneumoconiosis are more consistent with the objective evidence, I find that the Claimant has failed to establish that he has clinical pneumoconiosis. The analysis does not end here, however. I must also consider whether the Claimant has established that he has legal pneumoconiosis.

The Department of Labor has taken the position that coal dust exposure may induce obstructive lung disease even in the absence of fibrosis or complicated pneumoconiosis. This underlying premise was stated explicitly in the commentary that accompanied the final version of the current regulations. The Department concluded that "[e]ven in the absence of smoking, coal mine dust exposure is clearly associated with clinically significant airways obstruction and chronic bronchitis. **The risk is additive with cigarette smoking**." 65 Fed. Reg. at 79940 (emphasis added). Citing to studies and medical literature reviews conducted by NIOSH, the Department quoted the following from NIOSH:

> … COPD may be detected from decrements in certain measures of lung function, especially FEV1 and the ratio of FEV1/FVC. **Decrements in lung function**

> **associated with exposure to coal mine dust are severe enough to be disabling in some miners, whether or not pneumoconiosis is also present**.…

65 Fed. Reg. at 79943 (emphasis added). Moreover, the Department concluded that the medical literature "support[s] the theory that dust-induced emphysema and smoke-induced emphysema occur through similar mechanisms." Medical opinions which are based on the premise that coal dust-related obstructive disease is completely distinct from smoking-related disease, or that it is never clinically significant, are, therefore, contrary to the premises underlying the regulations. I have considered how to weigh the conflicting medical opinions in this case based on these principles.

Neither Dr. Traughber nor Dr. Powell offered any explanation why they attributed the Claimant's COPD entirely to cigarette smoke. Hence, I give their opinions little weight on the issue of legal pneumoconiosis.

Moreover, although Dr. Dahhan offered such an explanation, I find it to be inadequate. In his report, Dr. Dahhan stated:

> [The Claimant] has severe obstructive lung disease as noted by all physicians including the most recent exam from Dr. Selby. His obstructive lung disease is severe and associated with 1500 cc loss in his FEV1, an amount that cannot be explained by the possible loss of the FEV1 from 17 years of coal dust exposure; in addition, the patient is being treated with multiple bronchodilator agents indicating that his physicians believe it is responsive to such measures, another finding that is inconsistent with the permanent adverse affects of coal dust on the respiratory system. He has a history of bronchial asthma as well as the 50+ pack years of smoking, both sufficient to cause this degree of pulmonary impairment. Finally, he has no evidence of complicated coal workers' pneumoconiosis or progressive massive fibrosis that could case a secondary obstructive abnormality.

First, Dr. Dahhan's comments suggest that in order to attribute any of the Claimant's obstructive disease to coal dust exposure, the coal dust exposure would have to account for all of the loss in his FEV_1. This approach does not take into account any additive effect of coal dust exposure to the effects of smoking. Second, Dr. Dahhan attributed only 17 years of coal mine employment to the Claimant, while I have found 28 years of coal mine employment. Third, the fact that the Claimant's treating physicians have prescribed bronchodilators does not justify an inference that his obstructive impairment is completely reversible. Indeed, the pulmonary function tests in the record suggest that the Claimant's obstructive impairment shows no reversibility with bronchodilators. Fourth, the fact that the Claimant's history of smoking and asthma *could* account for his impairment, does not exclude coal dust as an additional component. Finally, the Department of Labor has concluded that coal dust can cause a loss of lung function, even when neither simple nor clinical pneumoconiosis is present. Dr. Dahhan's last point suggests that he does not accept this conclusion. For these reasons, despite his qualifications as a Pulmonologist, I find that Dr. Dahhan's opinion is entitled to less weight than those of the physicians who found legal pneumoconiosis to be present.

Dr. Selby's opinion suffers from similar defects as Dr. Dahhan's. On cross-examination, counsel for the Claimant asked Dr. Selby numerous questions in an attempt to clarify the reasons

for his opinion that coal dust did not contribute to the Claimant's obstructive lung disease. Reading Dr. Selby's testimony as a whole, despite some testimony which could be interpreted to the contrary, I conclude that Dr. Selby does not credit the concept of legal pneumoconiosis as defined in the Department of Labor regulations. Some of Dr. Selby's answers which lead me to this conclusion include the following:

> I mean, real pneumoconiosis before it got changed, back when it was straightforward and simple, pneumoconiosis only meant pneumoconiosis; that's a medical term. And medical pneumoconiosis, if you want to look at it that way, is a positive x-ray.
>
> …
>
> – but I'm a physician not a lawyer, and, so, as a physician, I look at things from a medical standpoint much more closely than from a legal standpoint; and, from a medical standpoint, [the Claimant] doesn't have any evidence for pneumoconiosis. If you want to try to say his obstructive lung disease is from coal mining, my answer would be no. Can obstructive lung disease come from coal mining? It's possible.
>
> …
>
> … I take each case as it comes. If there's an overwhelming amount of smoking – and we know that smoking causes the huge majority of any obstructive lung disease along with asthma in this country, and there's huge controversy about whether coal mine dust causes any clinically significant effective lung disease, you have to decide which path you're going to go down. Common things are common.

EX 2 at 31, 31-32, 33-34. These answers and other testimony by Dr. Selby lead me to the conclusion that absent evidence of clinical pneumoconiosis, he gives little credence to the premise that coal dust contributes to obstructive disease in a miner with a significant smoking history. The fact that smoking is a common cause of obstructive disease in the general population does not mean that coal dust does not contribute to obstructive disease in a miner who smokes. I also give Dr. Selby's opinion little weight on the issue of legal pneumoconiosis.

I find that the Claimant has established that he has legal pneumoconiosis based on the documented and reasoned opinions of Dr. Baker and Dr. Simpao.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for 10 or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2006). The Claimant was employed as a miner for 28 years, and, therefore, is entitled to the presumption. The Employer has not offered evidence sufficient to rebut the presumption.

Recently the 10th Circuit Court of Appeals held that the presumption applies only when the miner has established that he has clinical pneumoconiosis. *Anderson v. Director, OWCP*, 455 F.3d 1102 (10th Cir. 2006). In this case, I have found that the Claimant has established that he has legal, but not clinical, pneumoconiosis. I also find that he has established a causal relationship between his disease and his coal mine employment through the opinions of Dr. Baker and Dr. Simpao.

Causation of Total Disability

In order to be entitled to benefits, the Claimant must establish that pneumoconiosis is a "substantially contributing cause" to his disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 CFR § 718.204(c) (2006); *Tennessee Consol. Coal Co. v. Kirk*, 264 F.3d 602, 610 (6th Cir. 2001). The current regulations state that unless otherwise provided, the burden of proving a fact rests with the party making the allegation. 20 CFR § 725.103 (2006). The Benefits Review Board has held that § 718.204 places the burden on the claimant to establish total disability due to pneumoconiosis by a preponderance of the evidence. *Baumgardner v. Director, OWCP*, 11 B.L.R. 1-135 (1986). Nothing in the commentary to the new rules suggests that this burden has changed; indeed, some language in the commentary indicates it has not changed. See 65 Fed. Reg. at 79923 (2000) ("[t]hus, a miner has established that his pneumoconiosis is a substantially contributing cause of his disability if it either has a material adverse effect on his respiratory or pulmonary condition or materially worsens a totally disabling respiratory or pulmonary impairment …").

In *Toler v. Eastern Associated Coal Co*., 43 F.3d 109 (4th Cir. 1995), the Fourth Circuit Court of Appeals found it "difficult to understand" how an Administrative Law Judge (ALJ), who finds that the claimant has established the existence of pneumoconiosis, could also find that his disability is not due to pneumoconiosis on the strength of the medical opinions of doctors who had concluded that the claimant did not have pneumoconiosis. The Court noted that there was no case law directly in point and stated that it need not decide whether such opinions are "wholly lacking in probative value." However, the Court went on to hold:

> Clearly though, such opinions can carry little weight. At the very least, an ALJ who has found (or has assumed arguendo) that a claimant suffers from pneumoconiosis and has a total pulmonary disability may not credit a medical opinion that the former did not cause the latter unless the ALJ can and does identify specific and persuasive reasons for concluding that the doctor's judgment on the question of disability does not rest upon her disagreement with the ALJ's finding as to either or both of the predicates in the causal chain.

43 F.3d at 116. *See also, Scott v. Mason Coal Company*, 289 F.3d 263, 269-270 (4th Cir. 2002).

Drs. Baker and Simpao diagnosed legal pneumoconiosis, and opined that coal dust and cigarette smoking both contributed to the Claimant's pulmonary impairment. None of the other doctors who gave an opinion on this issue diagnosed pneumoconiosis. I can find no specific and persuasive reasons for concluding that the other doctors' judgment that coal dust did not contribute to the Claimant's disability does not rest upon their disagreement with my finding that

the Claimant has established that he has legal pneumoconiosis. I find that the Claimant has established that legal pneumoconiosis contributed to his disability within the meaning of the statute and regulations through the opinions of Drs. Baker and Simpao.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Medical evidence of total disability does not establish the date of entitlement; rather, it shows that a claimant became disabled at some earlier date. *Owens v. Jewell Smokeless Coal Corp.*, 14 BLR 1-47, 1-50 (1990). Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed unless the evidence establishes that the miner was not totally disabled due to pneumoconiosis at any subsequent time. 20 CFR § 725.503(b) (2006); *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-___, BRB No. 04-0812 BLA (Jan. 27, 2006), slip op. at 17.

The Claimant filed his first claim for benefits in October 1999. When he was examined by Dr. Traughber in November 1999, he was already totally disabled. The regulation regarding subsequent claims also provides, however, that "[i]n any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final." 20 CFR § 725.309(d)(5). The District Director issued his Proposed Decision and Order on the Claimant's prior claim on April 18, 2000. As he took no further action on that claim, it became final one year later, on April 18, 2001. I find that the Claimant is entitled to benefits commencing in April 2001, when his prior claim became final.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

The Claimant has met his burden to establish that there has been a change in one of the applicable conditions of entitlement, and that he is totally disabled due to pneumoconiosis. He is, therefore, entitled to benefits under the Act.

ATTORNEY FEES

The regulations address attorney's fees at 20 CFR §§ 725.362, .365 and .366 (2006). The Claimant's attorney has not yet filed an application for attorney's fees. The Claimant's attorney is hereby allowed thirty (30) days to file an application for fees. A Service Sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The other parties shall have ten (10) days following service of the application within which to file any objections, plus five (5) days for service by mail, for a total of fifteen (15) days. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits filed by the Claimant on September 23, 2004, is hereby GRANTED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the Administrative Law Judge's Decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative Law Judge's Decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC, 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC, 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's Decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).